302 837 PROFESSIONAL

302.1 GENERAL INFORMATION

Introduction

This chapter contains information on processing electronic claims based on the 004010X098 version of the ASC X12N Professional Health Care Claim (837P) Implementation Guide and the Addenda (004010X098A1) dated October 2002. This document will identify information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services (HFS).

Questions, comments, or suggestions regarding this information should be directed to hfswebmaster@illinois.gov

Billing Information

The professional 837 (837P) must be used to submit electronic claims to HFS for any service that is not currently submitted on the UB92, except for Home Health services. The ASC X12N Institutional Health Care Claim Implementation Guide (837I), not the 837P, must be used to submit electronic claims to HFS for Home Health services.

NOTE: Providers must continue using the same paper claim form that is submitted to The Department today. For example, physicians will continue to bill using the DPA 2360 and Durable Medical Equipment and Supply providers will use the DPA 2210.

Providers must continue to follow the policies outlined in the HFS provider handbooks, notices, rules and laws.

Abortion Claim – When a patient receives an abortion, the provider must continue to submit DPA Form 2390 – "Abortion Payment Application" to the Department by mail.

Amount Fields - The maximum number of characters to be submitted in the dollar amount field is nine (9) characters. Dollar amounts in excess of 9,999,999.99 (excluding commas and the decimal point) may be rejected.

Attachments – Providers who submit electronic claims that require an attachment must continue to separately mail the paper attachment to The Department. NOTE: No other submission method (fax, e-mail, electronic) will be accepted at this time.

All attachments must be accompanied by the Electronic Claim Attachment Form cover sheet. Providers must report the "Attachment Control Number" in PWK06 of the 2300 Loop. The PWK identifier should be unique for each claim. Providers must use the same PWK identifier for all attachments that apply to the claim. Providers will not be allowed to use the PWK identifier more than once, even for re-submittals or rebills.

In order to re-associate the attachments with the electronic claim, providers must submit all attachments for a claim accompanied by one cover sheet.

Claim Frequency (CLM05-3) – This element is required and is a new concept for NIPS providers. HFS will accept the following codes:

Code	Definition
1	Admit through Discharge Claim
7	Replacement of a Prior Claim or Service Line
8	Void/Cancel of Prior Claim or Service Line

The Department will only process Claim Frequency Codes 1, 7, and 8. If the Claim Frequency Code is 1, it will represent a normal claim. If the claim contains a frequency digit other than 1,7, or 8, it will be defaulted to “1” and processed as a normal claim.

Code Guidelines - The Department will process the following maximum number of codes and will not consider additional codes for adjudication and payment determination of the claims at this time.

Principal Diagnosis	1
Other Diagnoses	7
Diagnosis Code Pointers	4 per service line
Procedure code	1 per service line
Procedure Code Modifiers	4 per service Line

Coordination of Benefits – See Section 302.4 for more information.

Emergency – Providers will report “Y” in SV109 of Loop 2400 if a service was rendered because of an emergency.

EPSDT - - It is critical that providers utilize Special Program Code “01” in CLM12 of the 2300 Loop on claims where EPSDT services are provided. If EPSDT services are provided at the service line level, report “Y” in SV111 of the 2400 Loop.

Family Planning – It is critical that providers utilize element SV112 of Loop 2400 when Family Planning services are performed. This allows the Department to appropriately report services to CMS.

Modifiers - The Department will consider modifiers that impact the processing and/or pricing of the claim. See Chapter 200 of your provider handbook for more information.

With the implementation of the 837P, providers will need to report the "Purchase/Rental" with the appropriate two byte modifier, regardless of the date of service.

For dates of service prior to 4/1/04 and claims submitted on the 837P, the state generated local modifiers, which are one byte modifiers, must be reported in Loop 2400, Element SV101-03, Procedure Modifier. The one digit modifiers must be left justified followed by a space.

For anesthesiology claims providers should be submitting the two byte modifiers P1-P6. HFS will no longer accept and process the proprietary modifiers A-E.

= National Drug Code (NDC)

The department requires both the HCPCS code and the 11 digit NDC for administered or dispensed drugs. The NDC number is reported in the LIN segment of Loop ID-2410.

The Health Insurance Portability and Accountability Act (HIPAA) standard code set for NDCs is eleven digits, or a 5-4-2 configuration. Therefore, when submitting an NDC to the department, a leading zero must be added. (Refer to Informational Notice Dated March 29, 2006)

Reporting of Multiple NDCs
When billing for drugs with one HCPCS and multiple NDCs based upon the dosage administered, follow these procedures.

Service Line 1: HCPCS Code
Service Line 2: NDC
Service Line 3: HCPCS Code (same as Service Line 1) - Modifier 76 (Repeat Procedure)
Service Line 4: NDC
Service Line 5: HCPCS Code (same as Service Line 1 & 3) - Modifier 51 (Multiple Procedures)
Service Line 6: NDC

Patient - The patient is always the subscriber. Claim information should only be placed at the subscriber hierarchical level (even when using the mother's Recipient Identification Number to bill newborn services). Claims with information in the Patient hierarchical level will not be accepted into our processing system.

Place of Service – Providers will report the claims level "place of service" in CLM05-1 of the 2300 Loop, using one of the **two-digit** Facility Code Values. Service level "place of service" codes will overlay the claim level codes and should be reported in SV105 of the 2400 Loop.

Spenddown – If the subscriber owes a spenddown, you must report the amount in Loop 2300, AMT02-Monetary amount. This amount is currently received as TPL code 906. Co-payments should not be reported in this field. Co-payments will be automatically subtracted by the Department. Do not report co-payments on your claim forms or electronic billings. The paper DPA Form 2432 "Split Billing Transmittal Form" must also be mailed to the Department.

NOTE: Providers will no longer report the spenddown amount using TPL Code "906" when billing electronically.

Subscriber - The subscriber is always the patient. Claim information should only be placed at the subscriber hierarchical level (even when using the mother's Recipient Identification Number to bill newborn services). Claims with information in the Patient hierarchical level will not be accepted into our processing system.

Taxonomy - For HFS, the provider taxonomy code will be utilized to derive the Department's unique categories of service. The HIPAA Provider Taxonomy code is a ten-character code and associated description specified for identifying each unique specialty for which a provider is qualified to provide health care services. The providers must report in PRV01 of the 2000A Loop, code BI – "Billing Provider", which is equivalent to the Department's current "Provider" or PT – Pay-to, which is equivalent to our current "Payee." PRV02 must contain "ZZ", which is used to indicate the Provider Taxonomy Code. PRV03 must contain the Provider Taxonomy code, only if PRV01 contains "BI."

The Rendering Provider Name and Rendering Provider Taxonomy Code is **not** required by HFS in Loop 2310B, Elements NM1 & PRV, or in Loop 2420A, Elements NM1 & PRV.

Transportation – All transportation claims must utilize the one-digit modifiers to report the origin and destination of the transport. For complete instructions, see Section 302.51 for **emergency** claims and 302.52 for **non-emergency** claims.

Transportation claims, emergency and non-emergency, must report specific information about the trip in the NTE 2300 Loop. See Section 302.5 for complete information. The information contained in this field will apply to all service sections unless overridden in the 2400 Loop.

Void or Replacement of a Claim/Service Line – The Department will accept an 837 transaction to void or replace a payable or pending-payable claim, in place of its proprietary paper adjustment. See Section 302.3 for more details.

302.2 TECHNICAL INFORMATION

This section contains information relating to transmitting information to the Department. This section will identify, down to the data element level, anything unique to the Department in regards to the EDI transaction.

Transmission Information

The Department will continue to support its Recipient Eligibility Verification (REV) system. The REV system allows authorized Vendors a means to submit and receive electronic transactions, on behalf of Providers, for processing. The Department will also support a Medicaid Electronic Data Interchange (MEDI) system whereby authorized Providers and their agents can submit and receive electronic transactions via the Internet.

EDI Information:

The Department has identified, down to the data element level, anything unique to our processing requirements in regards to the various EDI transactions. This document will identify only those things that the Department requires that are not clearly identified in the Implementation Guide.

Note(s):

The "**billing provider**" name and number is equivalent to the current HFS provider number that is being used on the billing form or electronic NSF record.

The **"pay-to provider"** is the current one-digit pay-to code as identified on the Provider Information sheet.

HFS UNIQUE 837P ITEMS

IG Page #	Loop	Description	Element ID	Element Name	Remarks
67	1000A	Submitter Name	NM109	Identification Code	Must be your Federal Tax Identification Number
74	1000B	Receiver Name	NM103	Organization Name	Must be "ILLINOIS MEDICAID”.
			NM109	Identification Code	Must be "37-1320188".
79	2000A	Billing/Pay to Provider Specialty Information	PRV01	Provider Code	Must be "BI".
			PRV02	Reference Identification Qualifier	Must be "ZZ" to indicate Taxonomy.
			PRV03	Reference Identification	Taxonomy is required by HFS on all claims. The provider must submit the appropriate taxonomy for the service billed. The allowable range of taxonomy codes for each type of service is attached or will be submitted later. The complete list of taxonomy codes can found at www.wpc-edi.com.
84	2010AA	Billing Provider Name	NM103	Name Last or Organization Name	Must be the Provider's name exactly as it is shown on HFS's Provider Information Sheet.
91	2010AA	Billing Provider Secondary Identification	REF01	Reference Identification Qualifier	Must be "1D".
			REF02	Reference Identification	For HFS a secondary identification number is always required. REF02 must be the nine, ten or twelve-digit HFS Provider number as shown on the Provider Information Sheet.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
101	2010AB	Pay –To Provider Name	NM109	Identification Code	For HFS, the provider must enter their 9 digit Federal Tax Identification Number for their designated payee.
106	2010AB	Pay-To Provider Secondary Identification	REF01	Reference Identification Qualifier	Must be "1D".
			REF02	Reference Identification	The provider **must** enter the appropriate 1-digit payee number from the provider information sheet to identify which payee will receive payment for these services.
117	2010BA	Subscriber Name	NM103	Name Last or Organization Name	Must be the Last Name of the Recipient exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
			NM104	Name First	Must be the First Name of the Recipient exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
			NM105	Name Middle	Must be the Middle Name of the Recipient exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
			NM107	Name Suffix	Must be the Name Suffix of the Recipient exactly as it appears on the MediPlan Card, KidCare Card or SeniorCare Card.
			NM109	Identification Code	Must be the Recipient's 9-digit number as it is shown on the MediPlan Card, KidCare Card or SeniorCare Card.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
130	2010BB	Payer Name	NM103	Name Last or Organization Name	Must be "ILLINOIS MEDICAID".
			NM109	Identification Code	Must be "37-1320188".
170	2300	Claim Information	CLM01	Claim Submitter's Identifier	HFS will process and return up to 20 characters only.
			CLM05-3	Claim Frequency Type Code	For HFS the only valid codes are 1, 7 and 8.
210	2300	Date – Discharge	DTP03	Related Hospitalization Discharge Date	For HFS this element must be reported for therapies in order to determine if care is within 60 days or beyond 60 days of the hospital discharge.
214	2300	Claim Supplemental Information	PWK02	Report Transmission Code	Must be "BM", (by mail). If it is "BM", and there is a value other than blanks in PWK06, then a DCN that denotes that the claim had an attachment will be assigned.
220	2300	Patient Amount Paid	AMT02	Monetary Amount	If the subscriber owes a spenddown, you must report the amount in Loop 2300, AMT02-Monetary amount. This amount is currently received as TPL code 906. Co-payments should not be reported in this field. Co-payments will be automatically subtracted by the Department. Do not report co-payments on your claim forms or electronic billings. The paper DPA Form 2432 "Split Billing Transmittal Form" must also be mailed to the Department.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
227	2300	Prior Authorization or Referral Number	REF02	Reference ID	HFS strongly recommends that DME providers submit the Prior Authorization Number
229	2300	Original Reference Number (ICN/DCN)	REF02	Reference Identification	When billing for Claim Type 7 or 8, you must use this element to report the Document Control Number (DCN) of the original paid claim or service line that is to be voided or rebilled. See Section 302.3.
241	2300	Medical Record Number	REF02	Reference Identification	HFS strongly recommends that this data element be reported on all claims.
246	2300	Claim Note	NTE01	Note Reference Code	Must use "ADD" for **non-emergency** transportation claims.
			NTE02	Description	For all claims except emergency and non-emergency transportation, this element will contain the procedure literal description. For emergency and non-emergency transportation claims, this element will contain information about the trip. See Section 302.5 for a complete description.
248	2300	Ambulance Transport Information	CR106	Transport Distance	Transportation providers must report the number of “loaded” miles.
265	2300	Health Care Diagnosis Code	HI01-2	Industry Code	Required for all claims except transportation and laboratories.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
282	2310A	Referring Provider Name	NM101	Entity Identifier Code	Must be “DN” for: consultations, durable medical equipment, laboratory services, x-rays, and for a patient in the Recipient Restriction Program (RRP) if the referring provider is the Lock-In provider. The Lock-In provider’s Medicaid ID number must be reported in REF02, with a Reference Identification Qualifier of “1D” in REF01.
			NM108	Identification Code Qualifier	If the Referring physician is an enrolled provider, must use “1D” in REF01 to supply the attending physician’s HFS provider number in REF01
	2310A	Referring Provider Secondary Identification	REF01	Reference Identification Qualifier	If provider is enrolled, must use "1D" to supply the HFS provider number. If not enrolled with HFS, must use "0B" to supply your State License Number OR use "1G" to supply the UPIN OR use "SY" to supply your Social Security Number. The other identifiers will be ignored.
290	2310B	Rendering Provider Name	NM101-NM104		The Rendering Provider Name and Rendering Provider Taxonomy Code is **not** required by HFS.
293	2310B	Rendering Provider Specialty Information	PRV03	Reference Identification	

IG Page #	Loop	Description	Element ID	Element Name	Remarks
304	2310D	Service Facility Location	NM1		This loop is required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-To Provider) loops.
366	2330B	Claim Adjudication Date			FOR HFS this segment is required when loop 2320 is used.
368	2330B	Other Payer Secondary Identifier	REF01	Reference Identification Qualifier	Must be "2U".
			REF02	Reference Identification	For HFS a secondary identification number is always required when loop 2320 is used. Must be the 3-digit TPL code followed by the 2-digit Status Code assigned by HFS to other payers. For example: REF*2U*91001~ Code 910=Medicare Part B For other TPL codes, please reference Appendix 9 in Chapter 100. For Status Codes, see Appendix 1 in Chapter 200 of the Handbook for your provider type.
400	2400	Professional Service	SV101-03	Procedure Modifier	HFS will recognize and process up to four (4) modifiers per service line that impact the processing and/or pricing of the claim. See Chapter 200 of your provider handbook for more information.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
400	2400	Professional Service	SV103	Units or Basis for Measurement Code	Use MJ=Minutes to report anesthesia minutes and time for assistant surgeon. Use UN=Units for all other services provided.
412	2400	Ambulance Transport Information	CR103	Ambulance Transport Code	HFS will not recognize “X”=Round Trip. Each leg of the trip must be reported separately.
			CR106	Quantity	Must be the number of loaded miles traveled for transport by any type of vehicle.
435	2400	Date – Service Date	DTP02		HFS will only accept “D8”.
472	2400	Line Item Control Number	REF02	Line Item Control Number	If the provider completes this element, HFS will return it on the 835 when the claim is adjudicated.
485	2400	Approved Amount	AMT02	Monetary Amount	Must be the Medicare Approved Amount.
488	2400	Line Note	NTE01	Note Reference Code	Must use "ADD" for transportation claims.
488	2400	Line Note	NTE02	Description	For all claims except emergency and non-emergency transportation, this element will contain the procedure literal description. For emergency and non-emergency transportation claims, this element will contain information about the trip. See Section 302.5 for a complete description.

IG Page #	Loop	Description	Element ID	Element Name	Remarks
501	2420A	Rendering Provider Name	NM101-NM104		The Rendering Provider Name and Rendering Provider Taxonomy Code is **not** required by HFS.
504	2420A	Rendering Provider Specialty Information	PRV03	Taxonomy Code	
529	2420E	Ordering Provider Name	NM103-NM105	Name	HFS requires these elements for DME, Lab and Portable X-Ray claims.
			NM108	Identification Code Qualifier	Must use "34" to supply the Social Security Number. In addition, if the referring provider is enrolled with HFS, complete REF01 with “1D” and REF02 with the HFS provider number.
536	2420E	Ordering Provider Secondary Identification	REF01	Reference Identification Qualifier	HFS prefers the Medicaid provider Number (1D) for enrolled providers. If not enrolled, must use "0B" to supply the State License Number OR use "1G" to supply the UPIN OR use "SY" to supply the Social Security Number. The other identifiers are not acceptable.
554	2430	Line Adjudication Information	SVD02	Service Line Paid Amount	HFS will apply line level TPL payments, if reported.

302.3 VOID OR REPLACEMENT CLAIMS

The Department will now accept Claim Frequency Type Code (Bill Type) “7” (Replacement of a prior claim) and Claim Frequency Type Code (Bill Type) “8” (Void/Cancel of Prior Claim). This allows providers to void or replace a single service line or an entire claim.

The following data elements must match the original claim:

Document Control Number (DCN)	Loop 2300, REF02
Provider Number	Loop 2010AA, REF02
Recipient ID Number	Loop 2010BA, NM109

If these elements match, the service section or claim will be voided and the payment credited against a future voucher. If all three do not match, the transaction will be rejected.

If the elements for the new claim do not match the ones on the original claim, you must void the original claim with a Bill Type “8” and submit a separate replacement claim with the corrected information and the appropriate bill type (not 7 or 8).

302.31 VOID A PRIOR CLAIM (BILL TYPE “8”)

To void a single service line or an entire claim, enter Claim Frequency "8" in CLM05-3. If the DCN of the original payable or pending-payable claim, plus a Service Section of "00" is entered in REF02 of the 2300 Loop, the entire claim will be voided. If the DCN plus a Service Section number of greater than "00" from the original payable or pending-payable service line is entered, only that service line will be voided.

302.32 REPLACEMENT OF A PRIOR CLAIM (BILL TYPE “7”)

To replace a single service line or an entire claim, enter Claim Frequency "7". If the DCN of the original payable or pending-payable claim, plus a Service Section of "00" is entered in REF02 of the 2300 Loop, the original claim will be voided and replaced with the information contained in the resubmitted 837. If the DCN plus a Service Section number of greater than "00" from the original payable or pending-payable service line is entered, only that service line will be voided and replaced with the new information contained in the resubmitted 837.

302.4.1 COORDINATION OF BENEFITS (COB) INFORMATION

302.41 INSURANCE IN ADDITION TO ILLINOIS MEDICAID

For those claims where the subscriber has insurance in addition to Illinois Medicaid, utilize Loop 2330B, REF02 to report the 3-digit HFS TPL code, followed by the 2-

digit status code. The complete list of TPL codes can be found in Chapter 100, Appendix 9 of the General Policy and Procedures Provider Handbook. The list of Status Codes can be found in Appendix 1 in Chapter 200 of the Handbook for your provider type.

302.42 MEDICARE CROSSOVER CLAIMS

Until the National Provider ID (NPI) is implemented, utilize Loop 2330B, REF02 to report the HFS TPL code for those claims where the subscriber has Medicare coverage, followed by the 2-digit status code.

	Code
Medicare Part B	910

= The 910 Code, when utilized with the applicable status code, will assist HFS by clarifying the Medicare action.

302.43 COB - REPORTING PRIOR PAYMENT

Loop 2320 within the 837P can be used for reporting amounts paid by another payer including Medicare. Loop 2330B within the 837P can be used for Other Payer Secondary Identification.

302.44 COORDINATION OF BENEFITS

The Department does not accept COB claims from any other payer, **except** Medicare. Providers should submit claims to the Department in compliance with our current billing policies.

302.5 TRANSPORTATION INFORMATION

The following is a description of the workaround for transportation information to be used until specific loop segments will be made available (most likely in Version 4050), or until it becomes available in an electronic attachment:

For transportation claims, emergency and non-emergency trips, the State code where the Vehicle License Number was issued, the Vehicle License Number, and the Origin and Destination Name and Address must be reported in Loop 2300, Claim Note, NTE02 element. The information contained in this field will apply to all service sections unless overridden in the 2400 Loop.

NTE01: Value “ADD”

NTE02: State or Province Code, Vehicle License Number, Origin Time, Destination Time, Origin Address (including street, city, state and zip code), Destination Address (including street, city, state and zip code)

Example:

NTE*ADD* IL,12345678,1155,1220,1301 N OAKDAL, SPRIN IL 62703,409 S OAKDAL, SPRIN IL 62703~

The combined length of the note must not exceed **80** characters, including the "commas", and must follow these formats:

A. Each field must be separated with a comma.

B. The street address field must contain up to 13 characters of the street address, beginning with the address number. For example, the street address of 201 South Grand Avenue would be reported as "201 S GRAND A".

C. The city, state, zip field must contain up to 14 characters codes with up to five characters of the city, followed by one space, followed by the two character state designation, followed by one space, followed by the 5-digit zip code. For example, Chicago, Illinois 60606 would be reported as "CHICA IL 60606" and Ava, Illinois 63777 as "AVA IL 63777".

The preferred length for each field is listed below:

Length	Description
2	State or Province Code (Use Code source 22: States and Outlying Areas of the U.S.
8	Vehicle License Number
4	Origin Time Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59)
4	Destination Time Time expressed in 24-hour clock time as follows: HHMM, where H = hours (00-23), M = minutes (00-59)
13	Origin Address – Street
14	Origin Address – City State and Zip Code
13	Destination Address Street
14	Destination Address – City State and Zip Code

NOTE: The State or Province Code, Origin Time and Destination Time fields **must** contain the preferred length per field as listed above.

302.51 - Transportation Modifiers – Emergency Transportation Claims

Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit. Values of these Modifiers are

Modifier	Description
D	Diagnostic or therapeutic site, other than P or H when used as an origin code
E	Residential facility
H	Hospital
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Destination code only, intermediate stop at physician's office on the way to the hospital.

For example, if the patient is transported from his home ("R") to a physician's office ("P"), the modifier will be "RP".

302.52 - Transportation Modifiers – Non-Emergency Transportation Claims

Place Codes for origin and destination will be reported using Procedure Modifiers, and they will be reported with each procedure code billed. The one-digit modifiers are combined to form a two-digit modifier that identifies the transportation provider's place of origin with the first digit, and the destination with the second digit.

Non-emergency transportation claims must contain HIPAA compliant modifiers. This will require the provider to **map the HFS proprietary codes to the HIPAA codes accepted by HFS** as shown below. The allowable values of these Modifiers for Illinois Medicaid are:

HFS Proprietary Code	HIPAA Modifier Accepted by HFS	Description
E F G	D	Diagnostic or therapeutic site, other than P or H
B C	H	Hospital
A	P	Physician's office
H I K	R	Residence

For example, if the patient is transported from his home (“K”) to a physician’s office (“A”), the “K” will be changed to an ”R” and the “A” changed to a “P”, so the modifier reported on the 837P will be “**RP**”.

NOTE: Continue to report HFS’s proprietary codes (“KA” in this example) on **paper** claims.